

Central East **LHIN**

Save a Million Hours! Save Ten Thousand Days!

Engaged Communities. Healthy Communities.
Central East LHIN 2010-11 Annual Report

100,000 Hours - Save 10,000 Days

Statement of Intent

We, health service providers, health care professionals and clients within the Central East LHIN are committed to leading an integrated sustainable health care system that ensures better health, better care and better value.

Working in collaboration and by raising our aspirations, we are committed to making measurable improvements to achieve the Strategic Aims

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK (9)



The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs). LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas. LHINs received funding authority and the funding responsibility for their providers on April 1, 2007. This is the sixth Annual Report for the LHINs with their full authorities.

For more information about LHINs, including frequently asked questions, visit the Central East LHIN web site at www.centraleastlhin.on.ca.

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MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report – "Save a Million Hours! Save Ten Thousand Days!" – takes its title from the LHIN's May 2010 Symposium.

System goals which were articulated by the government – improve access to emergency department care by reducing the amount of time that patients spend waiting in the emergency department, improve access to hospital care by reducing the amount of time that patients spend in alternate level of care beds and improve access to integrated diabetes care – were translated into the LHIN's two Strategic Aims - *Save 1,000,000 hours spent by patients in hospital Emergency Departments by 2013 and Reduce the impact of Vascular Disease by 10% by 2013.*

In 2010/11 these system goals and strategic aims guided the collective activities of the system documented in this Annual Report.

The year however was not without its challenges.

Many of our health service providers had to make a number of difficult decisions as they dealt with historical deficits. Their effective community engagement, clear communications and patient-centered approach ensured that services continued to be accessible without impacting volume targets outlined in their accountability agreements.

It is important to note that all but one of the LHIN's nine public hospitals ended the year in a balanced position with the one remaining committed to achieving a balanced position by March 31, 2012.

This is an outstanding achievement for our LHIN and serves as an example of the value of the LHIN model as we work with our health service providers to ensure that an efficient and cost effective system of care is in place for the residents of the Central East region.

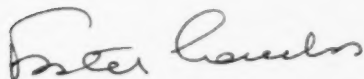
Despite changing clinical, economic and political climates, new Integrated Health Service Plans and new priorities, what have remained constant are our values, our vision, and our commitment to engaging the health care consumer and improving their health care experience through integration.

The LHIN's Mission Statement, unveiled in 2010/11, reads:

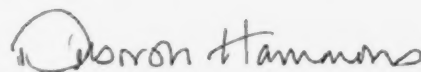
"To lead an integrated, sustainable health care system that ensures better health, better care and better value."

As always we would like to thank the hundreds of health service providers – doctors, nurses, allied health, support staff, administrators and volunteers – who dedicate themselves to their patients, clients, consumers and their families.

With their support we were able to implement so many of the innovative programs detailed in this report and we look forward to sharing ongoing updates on our collective progress in the coming months and years.



Foster Loucks,
Chair



Deborah Hammons,
CEO

MEMBERS OF THE BOARD

Foster Loucks, Chair

Term of Office:
June 1, 2005 – May 31, 2008
Reappointed:
April 1, 2008 – June 1, 2011



Joseline Sikorski, Vice-Chair

Term of Office:
June 1, 2005 – May 31, 2008
Reappointed:
April 1, 2008 – June 1, 2011



Jean Achmatowicz MacLeod, Secretary

Term of Office:
June 1, 2005 – May 31, 2008
Reappointed:
April 1, 2008 – June 1, 2011



Novina Wong, Member

Term of Office:
January 5, 2006 – February 4, 2007
Reappointed:
February 5, 2007 – February 4, 2010
Resigned: September 1, 2009



Stephen Kylie, Member

Term of Office:
March 1, 2006 – February 29, 2008
Reappointed:
March 1, 2008 – February 28, 2011



Dr. Alexander Hukowich, Member

Term of Office:
May 17, 2006 – June 16, 2007
Reappointed:
June 17, 2007 – June 16, 2010



Wayne Gladstone, Member

Term of Office:
June 15, 2010 – June 14, 2013



William Gleed, Member

Term of Office:
May 17, 2006 – June 16, 2007
Reappointed:
June 17, 2007 – June 16, 2010



Ronald Francis, Member

Term of Office:
May 17, 2006 – May 16, 2008
Reappointed:
May 17, 2008 – May 16, 2011



David Nichols, Member

Term of Office:
February 17, 2010 – February 16, 2013



Samantha Singh, Member

Term of Office:
June 17, 2010 – June 16, 2013



David Sudbury, Member

Term of Office:
June 17, 2010 – June 16, 2013



The governance structure for the LHINs is set out in the Local Health System Integration Act, 2006. LHINs operate as not-for-profit organizations governed by a board of directors appointed by the province. Each LHIN has a maximum of nine board members appointed by the Lieutenant Governor in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Lieutenant Governor in Council is responsible for designating the Chair and at least one Vice-Chair from among the members. The board of directors is responsible for the management and control of the affairs of the LHIN and is the key point of interaction with the Ministry. The board may pass by-laws and resolutions and may establish committees. Certain by-laws may require the Minister's approval. Details on the Central East Board of Directors can be found on the Central East LHIN web site at: <http://www.centraleastlhin.on.ca>

INTRODUCTION

The Central East LHIN is one of 14 Local Health Integration Networks that have been established by the Government of Ontario as community-based organizations to plan, co-ordinate, integrate and fund health care services at the local level including hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services and community health centres.

The Central East LHIN is one of the fastest growing geographic regions in the province and home to approximately 11% of Ontario's population. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km²). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park!

It should be noted that the Durham cluster has had a 22.4% increase in population over the past 10 years with seniors over the age of 65 providing the greatest increase in growth between now and 2030. Population diversity is concentrated in the western portion of the Central East LHIN (Scarborough and West Durham clusters) with 45% of the population not having English or French as their mother tongue. The Central East LHIN also has the second highest percentage in the province of families with children headed by a single parent and the third highest unemployment rate, resulting in related increases for mental health services for our community agencies as well as decreases in non-LHIN revenues for our hospitals.

Population Map



Source: MOHLTC Health Analytics Branch

	CENTRAL EAST LHIN	ONTARIO	LHIN Range ¹
Total population (2006)	1,432,705	12,160,282	34,130-208,035
Senior population, age 65+	13.7	13.6	9.4-17.2
Population with English mother tongue	72.1	69.8	51.5-91.5
Population with French mother tongue	1.4	4.4	1.0-23.9
Population who are immigrants	33.3	28.3	6.3-47.9
Population who are recent immigrants (2001-2006)	5.6	4.8	0.3-9.5
Population who are visible minorities	34.5	22.8	1.4-50.3
Population of Aboriginal identity	1.2	2.0	0.4-18.8
Labour force participation rate (15+)	65.6	67.1	60.1-71.5
Unemployment rate (age 15+)	7.3	6.4	5.2-8.4
Population in low income	16.1	14.7	9.6-24.0
Families (with children) headed by a lone parent	26.0	24.5	20.0-30.9
High school graduates aged 25 to 29	89.3	89.7	79.1-93.0
Post-secondary graduates aged 25 to 54	61.1	63.5	55.3-71.9

Source: 2006 Census of Canada, Statistics Canada ¹ Range refers to the range of values within the 14 LHIN areas.

MINISTRY/LHIN ACCOUNTABILITY AGREEMENT (MLAA)

What is an MLAA?

The Central East Local Health Integration Network (Central East LHIN) and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed an accountability agreement which defines the obligations and responsibilities of both the LHIN and the Ministry. The Ministry/LHIN Accountability Agreement (MLAA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and eHealth.

The MLAA is mirrored in the Accountability Agreements that LHINs have now negotiated with all health service providers.

MLAA Performance Indicators

The *Ministry-LHIN Accountability Agreement* clearly defines the relationship between the Ministry of Health and Long-Term Care and the Central East LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines respective performance targets within a pre-defined period of time. The following table outlines Central East LHIN performance against targets for 2010/11.

Central East LHIN MLAA Performance Indicators 2010/11

Performance Indicator	LHIN Starting Point 10/11	LHIN Performance Target – 10/11	Most Recent Quarter 2010/11 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2010/11 LHIN Annual Result
1. 90th Percentile Wait Times for Cancer Surgery	49	49	45	-8.2%	48
2. 90th Percentile Wait Times for Cardiac By-Pass Procedures	NA	NA	NA	NA	NA
3. 90th Percentile Wait Times for Cataract Surgery	127	140	111	-20.7%	153
4. 90th Percentile Wait Times for Hip Replacement	173	179	169	-5.6%	190
5. 90th Percentile Wait Times for Knee Replacement	171	179	166	-7.3%	187
6. 90th Percentile Wait Times for Diagnostic MRI Scan	107	77	80	4.6%	102
7. 90th Percentile Wait Times for Diagnostic CT Scan	41	36	28	-22.2%	28
8. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	18.41%	12.20%	21.29%	74.5%	20.22%
9. 90th Percentile ER Length of Stay for Admitted Patients	48.00	39.00	53.33	36.8%	51.62
10. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8.0	7.60	7.27	-4.4%	7.40
11. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	5.10	4.80	4.65	-3.1%	4.50
12. Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	15.20%	13.00%	17.72%	36.3%	16.75%
13. Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	20.60%	17.50%	19.79%	13.1%	18.77%
14. Readmission within 30 Days for Selected CMGs**	15.50%	15.30%	14.21%	-7.1%	14.77%

Note: *A negative percentage means that the LHIN has met its target.

** FY 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability

***FY 2010/11 is based on only 3 quarters of data (Q1-Q3 2010/11) due to availability

At the end of 2010/11, the Central East LHIN was able to **achieve eight performance targets** identified in its MLAA. A description of these eight targets and an explanation for the achievements follows:

Performance Indicator #1 – TARGET MET

90th Percentile Wait Times for Cancer Surgery

There was a lack of one-time incremental funding for certain cancer surgery types, with demand exceeding funded volumes. Note that only two of the Central East LHIN hospitals receive base funding from Cancer Care Ontario (CCO). Hospital-specific environmental and human resource issues had a significant impact on performance. Despite these challenges, actions taken to improve wait times including hospital-specific mitigation strategies such as increasing physician capacity and the resolution of data integrity issues have resulted in improved performance.

Performance Indicator #2 – TARGET N/A

90th Percentile Wait Times for Cardiac By-Pass Procedures

Not Applicable

Performance Indicator #3 – TARGET MET

90th Percentile Wait Times for Cataract Surgery

The most recent quarter 2010/11 (i.e. Q4) results for the Central East LHIN Surgical Wait Times demonstrate that our hospitals have performed at unprecedented rates, meeting or exceeding all LHIN targets. Improvement is attributed in large part to the Central East LHIN's working closely with providers through the Wait Time Strategy Working Group (WTSWG) and Wait Time Coordinators Group to carry out targeted improvement initiatives. Initiatives were directed at managing wait times from a systems perspective and included investments such as "the SUBMIT Project" which involves the implementation of a regional Central East LHIN surgical scheduling application, and data cleansing initiatives including physician education on the implementation of Decision Affecting Readiness to Treat (DART) procedures. Hospitals have been carefully monitoring Wait Times and LHIN engagement with Chiefs of Surgery, resulted in review of referral patterns, adjustments to operating room capacity and reallocation (in-year) of volumes. Overall, due to the sustainability and future impact of the majority of these initiatives, the Central East LHIN anticipates that performance will continue to improve and/or be maintained despite continuing pressures such as increased growth and demand for services.

Performance Indicator #4 – TARGET MET

90th Percentile Wait Times for Hip Replacement

Similar to Cataract Surgery – see text above.

Performance Indicator #5 – TARGET MET

90th Percentile Wait Times for Knee Replacement

Similar to Cataract Surgery and Hip Replacement – see text above.

Performance Indicator #7 – TARGET MET

90th Percentile Wait Times for CT Scan

Despite the overall good performance by the hospitals, there were continuing pressures such as scans that take longer to complete (complexity), aging machines and an increase in demand. Hospitals historically provided CT services above their funded volumes, but as hospitals remain committed to balancing and finding efficiencies, wait times have continued to be impacted. This was mitigated with LHIN-funded additional volumes. In 2011/12, the addition of two replacement and one re-purposed machine (in the ER) at The Scarborough Hospital will help to support the LHIN's targets.

Performance Indicator #10 – TARGET MET

90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients

Nine of the 13 hospitals operating Emergency Departments in the Central East LHIN are designated P4R (Pay for Results) hospitals. Enhanced staffing and process improvements provided through this funding stream have led to these reduced Emergency Department times.

Performance Indicator #11 – TARGET MET

90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients

Similar to 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients – see text above.

Performance Indicator #15 – TARGET MET

Readmission within 30 Days for Selected CMGs

Central East LHIN Readmission Rate performance in Q2 10-11 is 14.2% - 1% lower than previous quarter. This indicator is below the Central East LHIN negotiated target of 15.3%, and well below the provincial target in Q2 (16.2%). While the provincial trend has been upward from 15.5-16.2% in the past year, Central East LHIN performance has been improving. The Central East LHIN reported the largest improvement provincially (1.37%) and remains a top performer this quarter (rank 1st or 2nd). For the past three years, the Central East LHIN has dedicated significant energy to chronic disease primary and secondary prevention and management. These efforts have engaged providers in the implementation of initiatives designed to prevent ED visits, admissions, re-admissions and shorten length of stay.

At the end of 2010/11, the Central East LHIN was **unable to achieve five performance targets** identified in its MLAA. A description of these five targets and an explanation for the variance follows:

Performance Indicator #6 – TARGET UNMET

90th Percentile Wait Times for Diagnostic MRI Scan

Magnetic Resonance Imaging (MRI) wait times performance is expected to improve due to the various initiatives and mitigation strategies (e.g. data quality initiatives, MRI PIP, etc.) that are currently taking place with an even more significant improvement anticipated once the three new MRI machines at Ross Memorial Hospital, Rouge Valley Health System and The Scarborough Hospital are fully operational. Furthermore two hospitals were engaged in a "Process Improvement Project" (PIP) intended to assist in the reduction of MRI wait times and managing wait lists. An additional hospital is in the process of a PIP and the remaining hospitals will be participating in a lighter version of MRI PIP in 2011/12.

Performance Indicator #8 – TARGET UNMET

Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:

During FY2010, the Central East LHIN rolled out the Home First philosophy across all Central East LHIN hospitals. As a result, more ALC designated patients were discharged in this period than in previous periods, thus increasing the percentage ALC. Home First is designed to reduce the overall volume of ALC designated patients at every hospital, and eventually this reduction in cases will result in a reduction in %ALC. However, this reduction will take time to occur, as the discharge of ALC-designated patients cannot be hastened, but depends upon Long Term Care Home bed availability and post-acute capacity such as home care, rehabilitation services, and assisted daily living programs.

Performance Indicator #9 – TARGET UNMET

90th Percentile ER Length of Stay for Admitted Patients

The limiting factor for the flow of Admitted patients through the hospital is inpatient capacity. As the business processes involved in Home First are embedded and sustained at each Central East LHIN hospital, the overall volume of ALC patients will be reduced, thus increasing the capacity available to inpatients waiting in the ED. We expect a substantial reduction in this time in FY2011.

Performance Indicator #12 – TARGET UNMET

Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions

This is a relatively new indicator. Therefore, results are based on only two quarters of data from FY 10/11. The most recent release of data (May 13, 2011) refers to an annual result of 16.75% for the Central East LHIN, with the target being 15.20%. Other data sources indicate that the overall annual performance in this indicator is slightly better than what is reported here. The Central East LHIN is performing at about the Provincial Average for this indicator. Fiscal 10/11 marked a continuation in the ED avoidance strategy for Community Mental Health Programs that was undertaken in FY 09/10 with the formation of the "ED Avoidance Coalition". Although this formal coalition initiative ended on March 31, 2010, the relationships and level of Integrative Systemic practice have continued on. Mental Health Providers in the Central East LHIN have made a commitment toward developing strategies to avoid repeat unplanned ED visits by committing to this outcome in their Service Accountability Agreements. To date, the field has welcomed this first opportunity to measure its effectiveness through this new indicator.

Performance Indicator #13 – TARGET UNMET

Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions

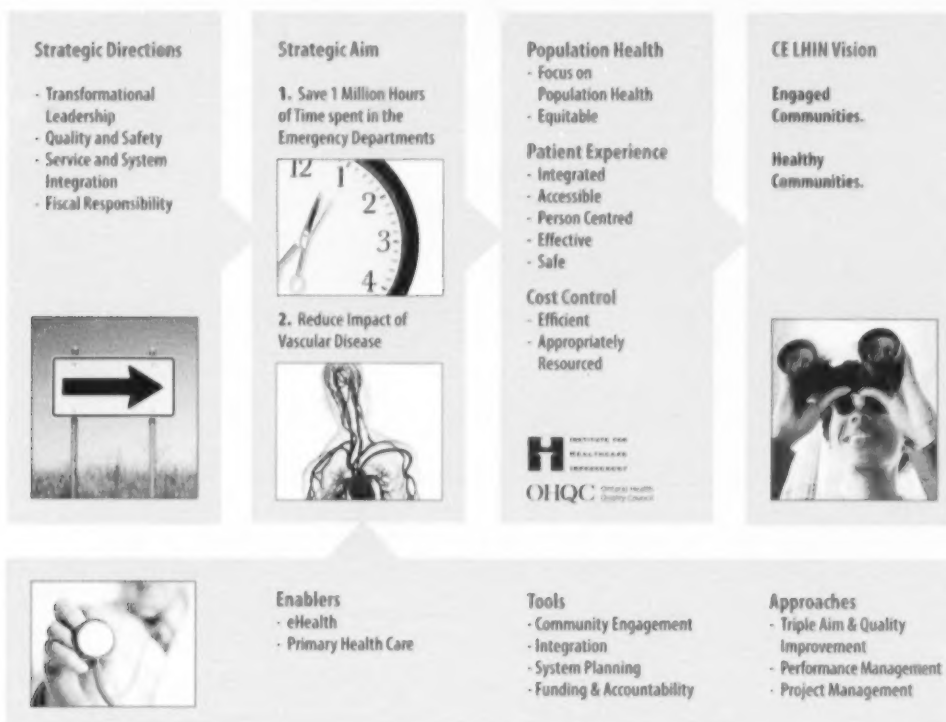
This is a relatively new indicator. Therefore the results are based on only three quarters of annual data. The most recent release of data shows an annual result of 18.77% for the Central East LHIN, with the target being 17.50%. More recent data shows that at year end, the Central East LHIN substantially outperformed the rest of the province. It has been noted both anecdotally and through the Addictions Scan that was undertaken by the Central East LHIN in 2008/09 that there is a lack of support available for Central East LHIN residents once initial Substance Abuse Withdrawal has occurred (Addictions Environmental Scan (2009). Despite the resource challenges, Addictions Health Service Providers have been strategizing to find ways in which to mitigate unscheduled return visits for Substance Abuse and Concurrent Disorder.

Central East LHIN Integrated Health Service Plan (IHSP)

In 2010/11, the Central East LHIN held its fourth annual Symposium "Save a Million Hours! Save Ten Thousand Days!" to launch its two strategic aims contained in the 2010/2013 Integrated Health Service Plan (IHSP):

- Save 1,000,000 hours of time patients spend in Central East LHIN emergency departments by 2013.
- Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

The Central East LHIN Strategy Map, which was included in the IHSP, highlighted how the LHIN's strategic directions of Transformational Leadership, Quality and Safety, Health Service and System Integration and Fiscal Responsibility provided the basis for decision making that would accomplish elements of a high performing system and which will achieve the vision of *Engaged Communities, Healthy Communities*.



Along with the two strategic aims, the IHSP identified segments of the population where initiatives should be prioritized. This included:

- Seniors
- People with a Mental Illness and/or Addictions
- People with Chronic Diseases
- Francophone Community and our Aboriginal partners

Implementation of the IHSP

Including ER Wait Times Initiatives/ Improving the ALC Situation

Important to the health care system and to hospitals in the Central East LHIN is decreasing patient flow times for treating and discharging patients through Central East LHIN emergency departments. Additionally, placement of patients classified as Alternate Level of Care (ALC) is a priority across the province and in the Central East LHIN. ALC is a complex system issue that impacts patient access to care, patient safety, and patient quality of life. It is costly to the health and well-being of the patient and their loved ones, and it is costly to the health care system.

It was expected that with the successful implementation of the strategic aims during 2010/11, the health system would have seen:

- A reduction in emergency department demand
- An improvement in patient flow within the emergency department
- More appropriate levels of care provided in the community for patients who no longer require acute care services within the hospital
- A reduction in the impact of vascular disease on individuals and the health care system
- A reduction in the number of hospital days associated with vascular diseases
- A decrease in the prevalence of co-morbidity for those patients with an existing primary chronic condition

With the support of health service providers across the Central East LHIN, the following initiatives were implemented in 2010/11 to address these government priorities as the LHIN continued to focus the system on the achievement of the two strategic aims. Where noted, these initiatives were also part of the fourth year of the Ministry/LHIN Aging at Home Strategy:

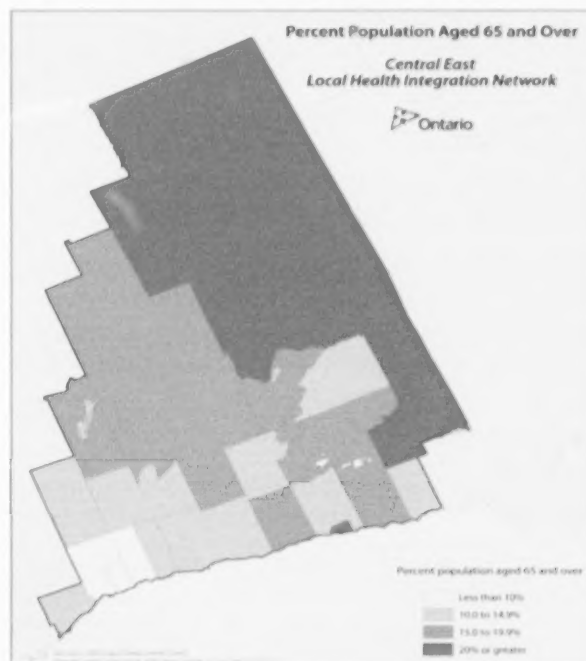
STRATEGIC AIM: Save 1,000,000 hours of time patients spend in Central East LHIN emergency departments by 2013.

Geriatric Assessment and Intervention Network (GAIN) – ongoing

In 2010/11, “Geriatric Assessment and Intervention Network” or GAIN clinics were opened at four Central East LHIN hospitals – The Scarborough Hospital (General site); Rouge Valley (Centenary campus); Lakeridge Health Oshawa and the Peterborough Regional Health Centre to ensure that frail seniors received the care they needed outside of an Emergency Department setting. This “Aging at Home” initiative has supported emergency room and community-based physicians in referring hundreds of seniors to these clinics for follow up assessments and treatment by an inter-professional care team. The GAIN clinics are further supported by dedicated geriatric in-patient units in each of the four hospitals that enable direct access to in-patient care for frail seniors.

<http://www.centraleastlhin.on.ca/Page.aspx?d=18660>

Percent Population Aged 65 and over



Source: MOHLTC Health Analytics Branch

Home First - ongoing

Rolled out across the Central East LHIN in 2010/11, "Home First" is an initiative led by the Central East Community Care Access Centre (CE CCAC) that helps patients transition from hospital to home. By March 2011, through partnership with all hospitals and local community support service agencies, the CE CCAC had supported over 3,000 individuals to be safely discharged from the hospital, with enhanced home care supports, so that they can make decisions related to future long term care needs in their own homes rather than a hospital bed, or remain in their home with care provided by the CCAC, community support service agencies and support by their families. This "Aging at Home" initiative had a significant impact on Alternate Level of Care (ALC) rates in the LHIN and will continue to be the focus of all partners in 2011/12.

<http://www.centraleastlhin.on.ca/Page.aspx?id=18658>

Geriatric Emergency Management Nurses - ongoing

The role of the Geriatric Emergency Management (GEM) Nurse is to deliver targeted geriatric assessments to high-risk seniors in the ED and to build capacity through knowledge transfer among ED staff and other health care partners (Regional Geriatric Program, 2009). ED staff calls on the specialized GEM nurse when an elderly patient meets the criteria for an assessment. Typically – though not always – these frail seniors are aged 75 years or older and their problems might include one or more geriatric syndrome: falls, delirium, dementia, depression, elder abuse, pressure ulcers, incontinence, malnutrition and functional decline. The GEM nurse position, which began in the Central East LHIN in 2007, was introduced to the province in 2004 and has since grown from one nurse to more than 65 across the province.

Regional Specialized Geriatrics Program Development – ongoing

In late 2010/11, the LHIN began a process to establish a Regional Specialized Geriatric Program. Building on previous investments, including eight GEM nurses, three Nurse Practitioner Outreach Teams to Long-Term Care, post-acute transition and restorative care programs, supportive housing and the four GAIN clinics, the LHIN determined that time has come to define how these services and programs will be woven together to result in a more coordinated continuum of care for frail seniors and their caregivers. It is expected that a report will be presented to the Central East LHIN Board of Directors in spring 2011 which will outline directions in this region.

<http://www.centraleastlhin.on.ca/Page.aspx?id=7096>

Residents First - ongoing

The Central East LHIN worked with the Ontario Health Quality Council (OHQC) (renamed Health Quality Ontario) throughout 2010/11 to host "Residents First Collaborative" events. This quality improvement initiative is focused on falls prevention in local Long Term Care Homes, an area of interest for all LHINs across the province. <http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=16612>

Timely Access for Seniors to Hospital and Community-based Services - ongoing

Funding made available through the province including the "Aging at Home" strategy allowed the LHIN to make a number of investments in 2010/11 that had an impact on the LHIN's Aim of saving time in the Emergency Departments and its focus on Seniors. These included:

- 12 new slow stream rehabilitation beds at Peterborough Regional Health Centre along with 7 Interim Long-Term Care Beds
- 15 new Convalescent Care beds at Strathaven Lifecare Centre in Bowmanville
- 20 new restorative care beds at Rouge Valley Health System – Ajax campus
- 8 new restorative/rehab beds at Northumberland Hills Hospital (NHH) as part of a new 16-bed Restorative Care Program
- The addition of staff with specialized skills in geriatric care and an enhanced schedule to provide rehabilitation care at NHH to support the emphasis on senior friendly care.
- The introduction of a Geriatric Activation Model of Care (Acute) at The Scarborough Hospital and a Geriatric Engagement and Reintegration Model of Care for The Hospitalized Elderly (GERI) at Ross Memorial

Hospital - both of which are focused on keeping seniors mobilized and active during their hospital stay so that they can be safely discharged home at the end of their acute treatment.

Provide Nurse Practitioner Outreach to Long-Term Care - ongoing

The Central East LHIN, working with the Ministry of Health and Long-Term Care, invested in three new NP outreach teams – in Scarborough, Durham and the North East cluster, which includes Peterborough, Northumberland, Kawartha Lakes and Haliburton. Launched in September 2010, the NP-led LTC outreach teams are collectively referred to as NPSTAT: - “Nurse Practitioners Supporting Teams Averting Transfers”. The NPSTAT program was developed to address the health risks of transferring frail seniors to emergency departments for visits which could be avoided if treated in the long-term care home. Reducing avoidable hospital visits and admissions will improve the health profile and health care experience of long-term care home residents, while maintaining or reducing the cost of providing appropriate care. When LTCH residents are hospitalized, NPSTAT can also help facilitate earlier discharges back to the LTCHs which can decrease hospital length of stay (LOS), enhance continuity of care and communication between acute and LTC sectors, and provide support and resources to LTCH staff to help manage repatriated LTCH residents.

<http://www.centraleastlhin.on.ca/Page.aspx?id=17706>

Pay for Results Year III - completed

Six Central East LHIN hospitals and one community agency participated in Year III of the provincial Pay-for-Results program and were measured against goals which included time to physician assessment and time to admission. These hospitals introduced a number of process improvements, which will be continued in 2011/12, in order to improve their results. This included having dedicated mental health crisis workers work with local police rather than transporting patients to the emergency departments, increased crisis staffing to support evenings and weekends, the creation of a dedicated “Medical Rapid Referral Clinic” to speed up triage, treatment and discharge and dedicated lab staff to the Emergency Department to improve on turnaround times for necessary tests.

http://www.centraleastlhin.on.ca/pressrelease.aspx?ekmense1=e2f22c9a_72_190_btnlink – see July 29, 2010

Community Crisis Support for Mental Health clients – ongoing

An innovative partnership between Durham Mental Health Services (DMHS) and Rouge Valley Health System has led to greater awareness of resources available in the community to clients presenting in local emergency departments and enhanced working relationships between community mental health service providers and their hospital partners. First introduced in late 2009, this program has seen the DMHS Mobile Crisis Team visit Rouge Valley’s emergency departments on a daily basis to support referrals and discharges to six community –based crisis beds or to the community, with support. Onsite psychiatric consultation, which started in early 2011, is provided by funding from the Ministry and the LHIN so that adults and youths can receive weekly psychiatric support through scheduled appointments. <http://www.dmhs.ca/files/crisis.pdf>

**Admissions†, discharges†, acute and total days† and average lengths of stay in designated mental health facilities,
Central East LHIN hospitals and Ontario, 2009/10**

Hospital	Admissions ‡	Discharges ‡	Acute Days†	Average Acute Length of Stay†	Total Days (excl. days away)†	Average Total Length of Stay (excl. days away)†
(4541) LAKERIDGE HEALTH CORPORATION-OSHAWA SITE	851	840	10,681	12.7	10,612	12.6
(4552) PETERBOROUGH REGIONAL HEALTH CENTRE	684	688	8,809	12.8	8,800	12.8
(4572) ROUGE VALLEY HEALTH SYSTEM-CENTENARY	1,262	1,241	14,606	11.8	14,690	11.8
(4573) SCARBOROUGH HOSPITAL (THE)-GRACE SITE	1,153	1,144	12,091	10.6	12,819	11.2
(4574) SCARBOROUGH HOSPITAL (THE)-SCAR.GEN.SITE	167	185	2,688	14.5	2,704	14.6
(4579) ONTARIO SHORES CTR FOR MENTAL HLTH SCIENCE	556	567	90,861	160.2	95,836	169.0
(4593) ROSS MEMORIAL HOSPITAL	410	414	4,404	10.6	4,269	10.3
Central East LHIN Total	5,083	5,079	144,140	28.4	149,730	29.5
Ontario Total	51,214	51,210	1,326,077	25.9	1,329,927	26.0

‡Admissions refer to cases that were admitted during the 2009/10 fiscal year

†Discharges, days and average lengths of stay are for cases discharged during the 2009/10 fiscal year, regardless of the year of admission. Acute days and average acute length of stay include the days when the patient was away from the mental health bed; total days and

average total length of stay exclude the days when the patient was away from the mental health bed

Source: Inpatient Adult Mental Health Table, [Ontario Mental Health Reporting System (OMHRS)], Intellihealth Ontario, Ministry of Health and Long-Term Care, Retrieved May, 2011.

Note that as of FY2006/07, adult mental health activity in designated beds is collected through the OMHRS and not the Discharge Abstract Database (DAD)

New MRIs for the Central East LHIN – announced December 2010

MRI wait times across the LHIN were expected to drop in 2010/11 and into 2011/12 when it was announced that two new MRI machines – one at The Scarborough Hospital – Birchmount campus and one at the Rouge Valley Health System – Ajax and Pickering campus – were to come online.

eHealth projects - ongoing

The **Timely Discharge Information System (TDIS)** ensures that family doctors and other community physicians receive information concerning a patient's hospital stay within 72 hours of transcription from the hospital. In Q3 of 2010, the number of reports available through TDIS grew from 1,411 in October to 7,466 in December. This included reports on patients' health information and their diagnostic imaging reports. An **eReferral project**, in partnership with the South East LHIN, provides Central East LHIN primary care physicians with a system that automates referrals to a specialist or specialty services. A **Surgical Utilization Management Integration Tool (SUBMIT)** provides an electronic solution to improving wait list management for Central East LHIN surgeons and support accurate reporting on Wait Times for surgical procedures.

<http://www.centraleastlhin.on.ca/Page.aspx?id=11808>

STRATEGIC AIM: Reduce the impact of vascular disease in the Central East LHIN by 10% by 2013.

CVDMPI - ongoing

CVDMPI or Comprehensive Vascular Disease Prevention and Management Initiative is a collaborative program created to find individuals at risk of Canada's number one cause of preventable death: vascular disease.

It is a program dedicated to education and informing patients about the risk factors of the disease, as well as its early detection, prevention, management and treatment. A joint health initiative between local and provincial health organizations and services who have come together to detect, prevent and manage vascular disease, this Peterborough based program assessed and treated over 1,200 local residents in 2010/11 as they supported the LHIN's strategic aim of reducing the impact of vascular disease.

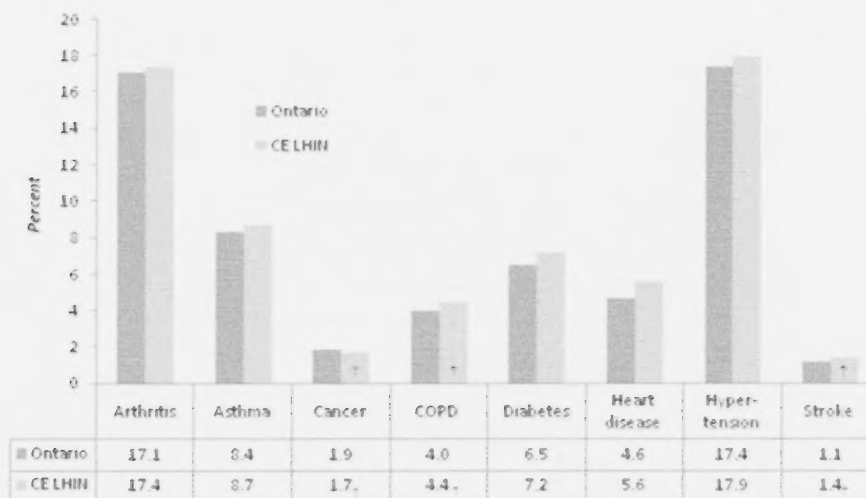
<http://www.centraleastlhin.on.ca/Page.aspx?id=17964>

Self Management for Consumers/Caregivers Priority Project – ongoing

The Central East Self-Management Training became a permanent program under the auspices of the Central East Community Care Access Centre in 2010/11. The Self-Management program, which delivers peer-led Stanford CDSM (Chronic Disease Self-Management) workshops, as well as training to health service providers in self management support and other leading edge self management-related activities, held 81 "Living a Healthy Life" self-management workshops in 2010/11 to 1,053 participants. Extensive redevelopment of the program website was undertaken to ensure that participants could register on line and data on the success of the program could be collected. Partnerships with providers across the LHIN ensured that the program was delivered to diverse audiences including French, Tamil and Chinese. The program has also established strong linkages with primary care and local hospitals to support staff education.

www.healthylifeworkshop.ca

Prevalence of selected chronic conditions (age 12+) Central East LHIN and Ontario, 2009



Source: 2009 Canadian Community Health Survey, Ontario Share File (Statistics Canada)

COPD is calculated for those aged 35+.

* Coefficient of variation 16.6% to 33.3% - interpret with caution.

Prevention and Management of Diabetes in the Central East LHIN - ongoing

Over 60,000 copies of a Diabetes Resource Guide entitled "*Living with Diabetes – What you should know*" are now in circulation – available in English, French, Tamil and Cantonese.
<http://www.centraleastlhin.on.ca/Page.aspx?id=10472>

Regional Kidney Disease Plan – ongoing

In September 2010, three hospitals in the LHIN's North East cluster – Peterborough Regional Health Centre, Northumberland Hills Hospital and Ross Memorial – along with the Peterborough site of Dialysis Management Centre Inc. (DMC) and the Peterborough Regional Nephrology Associates (PRNA) released a new strategic plan titled "2010-2013 Regional Renal Strategy." Developed in partnership with the Central East Community Care Access Centre, other community service organizations, and supported by the LHIN, the Strategy committed the partners to work together in providing a consistent patient experience across all organizations and collaborate in expanding access to home dialysis in the region. In March 2011, the LHIN provided the necessary funding that supported the partners in introducing home hemodialysis for eight patients.

Code STEMI expansion - ongoing

In 2010/11, the LHIN supported the expansion of the Code STEMI program into Durham Region and stronger partnerships between Lakeridge Health, Rouge Valley Health System (RVHS) and Durham Region Emergency Medical Services (EMS). The Code STEMI program provides percutaneous coronary intervention (PCI), or angioplasty, which unblocks narrowed arteries in the heart within 90 minutes of a patient presenting with cardiac symptoms, allowing more lives to be saved. In the event of specific types of heart attacks, Lakeridge Health's emergency department team now calls RVHS to activate the Code STEMI response. The patient is transported immediately via ambulance to the RVHS cardiac catheterization lab, located at Rouge Valley Centenary in east Toronto, for an angioplasty. Following the angioplasty, the patient is returned to Lakeridge Health's critical care department for ongoing care and recuperation.

http://www.centraleastlhin.on.ca/newsroom_display.aspx?id=15784

Community Engagement Activities

Community Engagement is the foundation of all activity at the Central East LHIN. Being more responsive to local needs and opportunities requires on-going dialogue and planning with those who use and deliver health services. Since 2005, board members and LHIN staff have actively engaged with local community residents, health care service providers, provincial associations, local government leaders and many other organizations and individuals on how to improve and enhance the public health system.

In February 2011, the Ministry of Health and Long-Term Care approved community engagement guidelines and a toolkit to be used by all LHINs in an effort to promote consistency across the province. By developing provincial guidelines, all 14 LHINs now have a consistent approach to community engagement planning and will be better able to show how feedback gathered through community engagement activities is considered as part of each LHIN's decision making process. <http://www.centraleastlhin.on.ca/Page.aspx?id=130>

Refreshed and new engagement structures, introduced with the launch of the 2010-2013 Integrated Health Service Plan, continues to support the LHIN as it works with local community stakeholders on enhancing the public health care system.

Francophone Initiatives

The Central East LHIN's French Language Health Services Collaborative continued in 2010/11, providing input to the Central East LHIN on the health care needs of French speaking residents.

In 2010, the provincial government created a regulation under the Local Health System Integration Act (LHSIA), 2006 related to Francophone community engagement and the Central East LHIN began working with its LHIN partners – Central and North Simcoe Muskoka - on developing a partnership with the provincially-named French language health planning entity #4 for Central South West Ontario.

It is expected that in 2011/12 the LHINs and the entity will confirm:

- the methods of engaging the francophone community in the area;
- identifying the health needs and priorities of the francophone community in the area, including the needs and priorities of diverse groups within that community;
- developing an inventory of health services available to the francophone community in the area and the identification and designation of health service providers for the provision of French language health services in the area;
- establish strategies to improve accessibility and integration of French language health services in the local health system; and
- overall planning and integration of health services in the area to better meet the needs of the francophone community.

French-Speaking Population in Central East LHIN

Sub-LHIN Planning Zone	Population who include French as mother tongue – total responses	% of population who include French as mother tongue
Haliburton Highlands	265	1.7%
Kawartha Lakes	870	1.2%
Peterborough City and County	1,650	1.3%
Northumberland-Havelock	920	1.2%
Durham East	5,070	2.3%
Durham West	5,470	1.98%
Durham North/Central	555	1.1%
Scarborough /Agincourt-Rouge	2,250	0.8%
Scarborough Cliffs – Scarborough Centre	3,285	1.2%
Total	20,360	1.4% of CE LHIN population

Aboriginal Initiatives

In 2010/11, the Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation, Métis Nation of Ontario, Mississaugas of Scugog Island First Nation and the Central East LHIN established a significant partnership to benefit the health, communities and the future of First Nations, Metis, Inuit and Non-Status people.

Through two advisory groups - the First Nations Health Advisory Circle and the Métis, Inuit, Non-Status People's Advisory Committee, the Central East LHIN has received advice on a variety of topics reflecting on provincial and Central East LHIN priorities pertaining to the First Nations people represented.

A "Celebration of Partnership" event on September 30th saw representatives from the five First Nations and the Central East LHIN come together for an historic signing of the Terms of Reference for the two advisory groups.

The Central East LHIN estimates that the First Nation, Métis and urban-based Aboriginal peoples residing in the region represents about one percent of the total regional population.

First Nation, Métis, Inuit and Non-Status people face a number of health issues and challenges and their health status is below that of the general population. First Nation, Métis, Inuit and Non-Status people have identified a number of barriers to receiving equitable access to health services including jurisdictional and funding issues, lack of sensitivity to their culture, and a lack of targeted programs that focus on their particular health needs.

One of the main goals of the Central East LHIN is to work with the First Nation, Métis, Inuit and Non-Status peoples to improve their overall health status. The Central East LHIN is committed to working with all Aboriginal people to align health services with existing regional, provincial and federal health planning, health programming and service delivery systems to improve health outcomes. See - <http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=18144>

Census Counts of Aboriginal Identity and Aboriginal Ancestry Populations – Central East LHIN, 2006

	Central East LHIN	Ontario
Total Aboriginal Identity Population	16,390	242,490
North American Indian single response	10,525	158,400
Métis single response	5,015	73,610
Inuit single response	210	2,035
Multiple Aboriginal response	100	1,905
Aboriginal responses not included elsewhere	600	6,540
Total Aboriginal Ancestry Population	34,515	403,795
Percent Population by Aboriginal Identity	1.2%	2.0%
Percent Population by Aboriginal Ancestry	2.4%	3.4%

Other Engagement Structures

Board to Board Engagement

On September 28, 2010, the Central East LHIN hosted a Board Governance Forum to share vital information with all Central East LHIN health service provider boards. The event included discussions of Provincial and Central East LHIN priorities, as well as integration expectations and opportunities. An outcome of this important event was the introduction of the Governance Advisory Councils, a model that is moving the board to board engagement dialogue forward and ultimately help us achieve a sustainable health care system in the Central East LHIN. Three Governance Advisory Councils were established in 2010/11 – in the Scarborough, Durham and North East – and a total of six meetings were held. These councils continue to meet on a quarterly basis to discuss issues of integration, quality and other concerns.

Strategic Aim Coalitions

First established in May 2010, coalitions were formed to provide leadership to the achievement of the LHIN's Strategic Aims.

The *Vascular Health Strategic Aim Coalition* is comprised of fifteen individuals from acute, community and long term care home sectors. During 2010/11 the coalition developed a "Model for Vascular Health in the Central East LHIN" and identified a number of Vascular Health priority initiatives including:

- a Central East LHIN hospital-based Smoking Cessation Initiative
- an education initiative highlighting the latest in diabetes care and prevention for all Central East LHIN primary care providers
- an evidence-based model of Cardiovascular Rehabilitation services for the 401 corridor of the LHIN
- investing in PCI in the North East cluster, specifically the Peterborough Regional Health Centre
- the formal integration of existing vascular services between The Scarborough Hospital and the Rouge Valley Health System and between Peterborough Regional Health Centre and Lakeridge Health

Health Professionals Advisory Committee (HPAC)

Like all LHINs, the Central East LHIN has established a Health Professionals Advisory Committee. This committee is responsible for assisting the LHIN in carrying out its responsibilities by providing advice on how to achieve patient-centered health care.

Partnership with Public Health

In the Central East LHIN, bimonthly meetings are held with the Medical Officers of Health (MOH) from the four Public Health Units in the region. Chaired by the LHIN CEO and one of the MOHs, the group met on a bi-monthly basis in 2010/11 to review best practices related to infection control, outbreak and system surge management, falls prevention and smoking cessation.

Central East Executive Council (CEEC)

Senior Administrators from the Central East LHIN, all Central East LHIN hospitals and the Central East Community Care Access Centre meet on a monthly basis to review shared projects and initiatives that support the system's goal of reducing ED wait time and reducing the impact of vascular disease.

Medical Leadership Group/VPs and Chief Nursing Executives

Strong partnerships with hospitals' Chiefs of Staff and Chief Nursing Executives, formed during the development of the first "Clinical Services Plan", continued in 2010/11 and the LHIN continued to meet with these groups to discuss system wide deliverables and the development of regional programs and initiatives.

Central East Hospice Palliative Care Network

Members of the hospice palliative care sector within Central East integrated three predecessor End-of-life Care Networks operating in Central East: Durham Region End-of-Life Care Network; Haliburton, Kawartha and Pine Ridge End-of-Life Care Network; and Toronto Palliative Care Network-East Region into the Central East Hospice Palliative Care Network under the direction of the Central East Community Care Access Centre. The Network advised both the CE CCAC and the LHIN on palliative care planning and co-ordination to support the LHIN's Strategic Aims.

Central East LHIN Self-Management Program Advisory Council

The Program Advisory Council was established in April 2010 to provide strategic advice on the implementation of the Self Management program, recommend partnerships with other stakeholders and review program outcomes, case studies and best practices. Meetings are held four times a year.

E-health Steering Committee

The Central East Local Health Integration Network's eHealth Steering Committee, which meets on a quarterly basis, has continued to provide active leadership in developing and implementing the Central East LHIN eHealth Strategy and Tactical Plan to enable LHIN health care providers to leverage the potential of Information and Communications Technology (ICT).

Hospital/CCAC Financial Leadership Group

The HCFL Work Group provides expert content-knowledge, directional leadership and expertise in financial management within a collaborative forum in accordance with Central East LHIN priorities and strategies (e.g. IHSP). At their monthly meetings, members identify and examine current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services.

Primary Care Working Group (PCWG)

The Primary Care Working Group continues to provide expert advice to the Central East LHIN on current and emerging trends and issues in primary health care and population health. At its monthly meetings and through the ongoing leadership of its chair, the PCWG continues to work with all stakeholders and the Central East LHIN to support and promote best practices to create an efficient patient centered health care system that will better navigate our patients safely through their journey of care.

Wait Time Strategy Working Group

The Wait Time Strategy Work Group provides directional leadership, content-knowledge and expertise in planning and implementing specific initiatives within a collaborative forum in accordance with Central East Local Health Integration Network priorities and strategies (e.g. IHSP) as well as with the current Wait Time Strategy. The aim is to improve priority area wait times across the Central East LHIN, while easing patient flow and maintaining quality along the broader continuum of care. Also, in parallel, members utilize their role to identify and examine current emerging issues and/or anticipated future items. Based on this assessment, efforts are focused on the development and implementation of innovative solutions addressing the perceived opportunities for the integration/coordination of more streamlined and efficient health care services. In 2010/11, this group worked collaboratively to ensure that allocated Wait Times funding is used effectively across the system. Prior to the establishment of this group, the Central East LHIN had to return \$1,521,100 in Wait Times Strategy funding to the Ministry of Health and Long-Term Care because the hospitals were unable to deliver all of their volumes. In 2010/11, the Wait Times Strategy Working Group, using monthly surveys and information sharing, reallocated volumes to the areas of greatest need and the year end recovery was estimated to be \$2,800.

System Surge Management Committee

The Central East LHIN System Surge Management Committee is a group of individuals comprised of hospital senior administration, LTCH senior management, ethicists, Central East CCAC senior management, the Central East LHIN Primary Care Lead, Central East LHIN Critical Care Lead, and Central East LHIN Staff (Senior Director of SDI, Communications Lead, Implementation Consultant, Health Planner). The Central East LHIN System Surge Management Committee meets bi-monthly when there is no existing surge or pending surge activity. Overall the System Surge Management Committee continued over the past year to provide an effective and efficient forum for managing and coordinating system level response to moderate surge and major surge events impacting the local health care system (Surge is any health care situation where demand exceeds capacity). Furthermore, the Committee has provided an opportunity for communication and sharing of best practices between health care providers, local public health officials (others, e.g. EMS) in the event of a regional/sub-regional moderate or major surge event. The Central East LHIN System Surge Management Committee is currently working on the development of a Ventilation Best Practices Protocol to ensure timely, effective and consistent use of ventilators throughout the Central East LHIN in times of surge activity.

Other Engagement Activities

Central East LHIN Symposium

Health service providers - their staff, physicians, board members, administrators - community leaders and residents from across the Central East region participated in the *Central East LHIN's "Save a Million Hours! Save Ten Thousand Days!" Symposium* held at the Ajax Convention Centre on May 5, 2010. The event was hosted by the newly formed Strategic Aim Coalitions (Emergency Department and Vascular Health) and provided Coalition members with an opportunity to obtain input from stakeholders on how the LHIN's two Strategic Aims as outlined in the 2010-2013 IHSP would be achieved.

Open Board meetings

Held each month at the LHIN's office in Ajax, *Open Board meetings* continued to provide stakeholders with the opportunity to witness and observe the work being done by the Board of Directors of the Central East LHIN to enhance a stronger health care system that will be there for our children and our grandchildren. Board meetings and board committee meetings were held on a regular basis so that information could be reviewed and discussed by the Board to assist in the decision making process. Materials from all the meetings were posted to the Central East LHIN website and stakeholders were alerted to this posting through a web-enabled MY PAGE system.

Sector Based Providers

Targeted engagement with sector based providers in the Central East LHIN supported the sharing of information as LHINs worked with hospitals, community based agencies and long-term care homes on completing annual service accountability agreements. Information shared at these sessions was posted on the Central East LHIN website so that stakeholders from across the LHIN could see the work being done by these providers to provide accessible, efficient and quality health care services.

Physician Engagement

The Central East LHIN continued to *engage with its physicians*. An example of this is participation in annual CME events. This included an event at Tosca Banquet Hall in Oshawa on May 26, 2010 and another at Markham Event Place in November 2010. A new Primary Care Physician Engagement Resource Guide and Toolkit created in partnership with Ontario Medical Association and Ontario College of Family Physicians and posted on all LHINs' websites in December 2010, provides LHINs with a range of preferred engagement techniques that can be used to strengthen physician relations and enhance collaboration.

Regional, County and Municipal Councils

The Central East LHIN continued to *visit regional, county and municipal councils in 2010/11* to provide updates to local elected officials on the work being done to improve the local delivery of health care services to their residents and constituents.

MPP Engagement

Ongoing meetings between *LHIN leadership and the Members of Provincial Parliament* from all Central East ridings helped to ensure that these provincial leaders were aware of LHIN initiatives that would be benefitting their local constituents.

Speakers' Bureau

LHIN staff and board members attended a number of third-party events in 2010/11 as part of the "*Speakers' Bureau.*" This included health service providers' Annual General Meetings, public announcements and open houses. This provides the LHIN with an opportunity to hear from local stakeholders on local issues and opportunities for improvement, but also an opportunity for the LHIN to inform the public and stakeholders.

Integration

One of the main goals of each LHIN is the integration of health care services to create a more efficient health care system while at the same time improving the health care experience by creating a seamless system of care. In 2010/11, the Central East LHIN continued to support integration activities through the following:

Organizational Health – Self Assessment Tool

In December 2010, the Central East LHIN posted a self assessment tool for use by community support services and community mental health and addictions agencies to quickly assess their organizational health status. Developed by the Central East LHIN and shared with all stakeholders, the tool is an important resource for a health service provider to consider as they assess whether they are effectively and efficiently providing client/patient services in an accountable manner. Completing the assessment allows agency boards and senior executive leaders to assess the health status of their organizations which may then suggest action, including integration opportunities, to mitigate the issues identified.

<http://www.centraleastlhin.on.ca/Page.aspx?id=96>

Facilitated and Negotiated Integration Process and Requirements Guide

In December 2010, the Central East LHIN produced a "Facilitated and Negotiated Integration Process and Requirements Guide" to support Central East LHIN funded health service providers through the process of planning and implementing a facilitated or negotiated integration. It was also shared with all stakeholders and posted on the Central East LHIN website.

<http://www.centraleastlhin.on.ca/Page.aspx?id=96>

Integration Activities

Integration accomplishments in 2010/11 included:

Enhanced mental health services through regional collaboration

Approved in late April 2010, a voluntary integration between Northumberland Hills Hospital (NHH) in Cobourg and Ontario Shores Centre for Mental Health Sciences in Whitby has benefited patients, family members and staff and has had a measurable impact on the quality of mental health care in the northeast cluster of the LHIN. As a result of the integration, the intake process was redesigned which led to a 53.6% improvement in access. NHH staff and physicians now have access to specialized mental health and psychiatric consultations through Ontario Shores in the areas of adolescents, forensics and dual diagnosis. A new crisis intervention model was designed and implemented in NHH's Emergency Department.

Improved access to local hospice services in Northumberland County

A facilitated integration, initiated at the request of Hospice Northumberland Lakeshore and Palliative Care Campbellford in July 2010, saw the two local hospice agencies integrated with Community Care Northumberland so that hospice clients and their families had streamlined access to a broader range of community services. Completed in December 2010, this integration allowed the LHIN to transfer responsibility for service delivery and the associated funding to Community Care Northumberland and created an efficient service delivery model that improved access, navigation to community services, supported local governance and streamlined approaches to management, back office support, volunteerism and fundraising.

http://www.centraleastlh.in.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Integration_Plan_FINAL.pdf

Sustainable hospice services achieved in the City of Kawartha Lakes

Another facilitated integration in the City of Kawartha Lakes, initiated in November 2010, saw hospice services previously delivered by Hospice Kawartha Lakes (HKL) become part of the basket of services delivered by Community Care City of Kawartha Lakes. At the request of the board of HKL, the LHIN team worked with representatives from both organizations to ensure that local hospice services were sustained over the long-term and to enable hospice clients to have easier and seamless access to a broader range of community support services.

http://www.centraleastlh.in.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Integration_Plan_December_10_2010_Final.pdf

Central East Regional Thoracic Program

Supported by the Central East LHIN's Board of Directors and implemented in January 2011, the voluntary integration of all hospital thoracic surgical services to Lakeridge Health Oshawa (LHO) ensures that patients from across the LHIN now have access to coordinated, patient-centred, high quality and integrated thoracic oncology service. Patients are now referred to a Thoracic Diagnostic Assessment Unit in Peterborough, Oshawa or Scarborough, close to their home community, where a nurse navigator is assigned to work closely with patients and their families to ensure care is coordinated and navigated along an agreed path with all information available to patients when they need it.

<http://www.lakeridgehealth.on.ca/article.php?id=AYQ-24Q&navID=listMenuRootV>

Consumer/survivor mental health services in the City of Kawartha Lakes

Potential problems with financial controls at the Survivors Psychiatric Advocacy Network (S.P.A.N.), a Central East LHIN-funded health service agency that provided peer support and other community-based services to mental health consumers/survivors in the City of Kawartha Lakes area, prompted its Board to work on a facilitated integration with the Canadian Mental Health Association (CMHA) – Peterborough Branch in early 2011. At the March 23, 2011 open board meeting, the Board of the Central East LHIN issued a decision to support the facilitated integration of Survivors Psychiatric Advocacy Network (S.P.A.N.) in Lindsay with the Peterborough Branch of the Canadian Mental Health Association.

With this decision, consumer survivor services, previously provided by S.P.A.N. will now be integrated into the services provided through CMHA-Peterborough.

<http://www.centraleastlh.in.on.ca/Page.aspx?id=19144>

Consumer survivor initiatives in Durham Region

Board members from the United Survivors Support Centre (USSC), a peer-run mental health organization funded by the LHIN and based in Oshawa, determined that they had some challenges in meeting their accountability agreement with the LHIN, in November 2010 they asked for the LHIN's support in facilitating an integration with CMHA-Durham Region and Durham Mental Health Services. With the support of the respective boards, the integration was approved in January 2011 and Durham Mental Health Services and CMHA-Durham moved forward with their plans to ensure that mental health consumers/survivors and their families had access to local peer supports, as close to home as possible.

http://www.centralcastlhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Integration_Plan_January_11_2011_Final_Adjusted.pdf

ANALYSIS OF CENTRAL EAST LHIN OPERATIONAL PERFORMANCE

In 2010-11 the Central East LHIN received a total operating budget of \$5.7 million which included operations at \$4.7 million and additional funding of \$1,012,000 as noted in the financial statements (note 8). The additional funding for special projects allowed the LHIN to pursue initiatives such as Aboriginal health planning, evaluating and monitoring emergency care performance, e-Health projects and continued support to the French Language Services. The Central East LHIN exercised prudent fiscal management to balance its internal operations budget and met the objective target of less than 1.8% in surplus.

During the fiscal year the Central East LHIN redesigned its organizational structure to better support the achievement of the LHIN's strategic aims and to improve collaboration for our internal work flow processes. Staff roles and responsibilities now include a matrix model with assigned co-leads acting as "points of contact" for each sector reporting to the LHIN – hospitals, the CCAC, community support services and community health centres, mental health and addiction providers and long term care homes. The LHIN's Performance Management Program was also redesigned to ensure that all positions support the organization's objectives through the achievement of specific goals and objectives and identification of development opportunities.

The Central East LHIN Code of Conduct, which was developed by LHIN staff throughout 2010 and adopted by the LHIN's Board of Directors in November 2010, is intended to be a central guide and reference for all employees and the Board in support of day-to-day interactions and decision making, and to help employees and the Board work more effectively together. The structure to support the successful implementation of the Code included ongoing promotion with staff, development of a compliance procedure, ongoing policy development and education initiatives.

http://www.centraleastlhin.on.ca/Page.aspx?id=18896&ekmense1=c2f22c9a_72_184_18896_2

The Central East LHIN organization is comprised of three distinct units – Corporate (Governance, Communications, Business Support); System Design and Implementation (Integration, Quality Improvement, System Planning) and System Finance and Performance Management (Finance, Performance). With additional support from Health Force Ontario and Health Quality Ontario, the staff complement of 33 FTEs effectively managed a \$2 billion health service system on behalf of the residents of the Central East LHIN.

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Central East Local Health Integration Network

We have audited the accompanying financial statements of the Central East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2011, and the statements of financial activities, changes in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2011, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 25, 2011

Statement of Financial Position

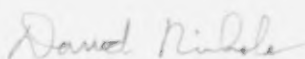
as at March 31, 2011

	2011	2010
	\$	\$
Financial assets		
Cash	1,008,629	536,038
Due from Ministry of Health and Long Term Care ("MOHLTC")	13,911,183	1,533,500
Accounts receivable	37,840	1,192,464
	14,957,652	3,262,002
Liabilities		
Accounts payable and accrued liabilities	531,482	1,423,365
Due to Health Service Providers ("HSP")	13,911,183	1,533,500
Due to MOHLTC (Note 3b)	541,295	354,269
Deferred capital contributions (Note 5)	315,287	369,310
	15,299,247	3,680,444
Commitments (Note 6)		
Net debt	(341,595)	(418,442)
Non-financial assets		
Prepaid expenses	26,308	49,132
Capital assets (Note 7)	315,287	369,310
	341,595	418,442
Accumulated surplus	-	-

Approved by the board



Director



Director

Statement of Financial Activities

year ended March 31, 2011

		2011	2010
	Budget (unaudited) (Note 8)	Actual	Actual
	\$	\$	\$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	1,947,201,383	2,042,808,997	1,923,766,995
Operations of LHIN	4,772,730	4,659,791	4,452,752
Emergency Department ("ED") Lead (Note 10a)	75,000	75,000	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") (Note 10b)	100,000	100,000	100,000
Aboriginal Planning (Note 10c)	20,000	20,000	20,000
e-Health (Note 10d)	632,000	632,000	1,885,000
Critical Care	75,000	75,000	-
French Language Services	110,000	170,116	113,584
Aboriginal Health Transition Funding carry-over 2009-10	-	47,202	3,798
Self Management Program	-	-	35,000
Diabetes Strategy	-	-	20,000
Amortization of deferred capital contributions (Note 5)		166,962	260,893
	1,952,986,113	2,048,755,068	1,930,733,022
Expenses			
Transfer payments to HSPs (Note 9)	1,947,201,383	2,042,808,997	1,923,766,995
General and administrative (Note 11)	4,772,730	4,748,677	4,664,979
ED Lead (Note 10a)	75,000	69,290	75,000
ER/ALC (Note 10b)	100,000	96,714	100,000
Aboriginal Planning (Note 10c)	20,000	-	20,000
e-Health (Note 10d)	632,000	356,450	1,707,447
Critical Care	75,000	72,000	-
French Language Services	110,000	51,665	13,584
Aboriginal Health Transition Funding carry-over 2009-10		9,980	3,798
Self Management Program		-	35,000
Diabetes Strategy		-	20,000
Resident's First program		-	900
	1,952,986,113	2,048,213,773	1,930,407,703
Annual surplus before funding repayable to the MOHLTC	-	541,295	325,319
Funding repayable to the MOHLTC (Note 3a)		(541,295)	(325,319)
Annual surplus	-	-	-
Opening accumulated surplus			-
Closing accumulated surplus	-	-	-

Statement of Changes in Net Debt

year ended March 31, 2011

	Budget (unaudited) (Note 8)	2011	2010
		\$	\$
Annual surplus	-	-	-
Acquisition of tangible capital assets	-	(112,939)	(249,478)
Amortization of tangible capital assets	-	166,962	260,893
Change in other non-financial assets	-	22,824	(37,803)
Increase in net debt	-	76,847	(26,388)
Opening net debt	-	(418,442)	(392,054)
Closing net debt	-	(341,595)	(418,442)

Statement of Cash Flows

year ended March 31, 2011

	2011	2010
	\$	\$
Operating transactions		
Annual surplus		-
Less items not affecting cash		
Amortization of capital assets	166,962	260,893
Amortization of deferred capital contributions (Note 5)	(166,962)	(260,893)
	-	-
Changes in non-cash operating items		
(Increase) decrease in due from MOHLTC	(12,377,683)	(48,200)
Decrease in accounts receivable	1,154,624	(1,186,277)
Increase in accounts payable and accrued liabilities	(891,883)	193,068
Increase (decrease) in due to HSPs	12,377,683	48,200
Increase (decrease) in due to the MOHLTC	187,026	325,319
(Increase) decrease in prepaid expenditures	22,824	(37,803)
Decrease (increase) in due to the LHIN Shared Services Office	-	(7,546)
	472,591	(713,239)
Capital investments		
Acquisition of tangible capital assets	(112,939)	(249,478)
Financing transactions		
Capital contributions received (Note 5)	112,939	249,478
Net decrease in cash	472,591	(713,239)
Cash, beginning of year	536,038	1,249,277
Cash, end of year	1,008,629	536,038

Notes to Financial Statements

1. Description of business

The Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km²). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park. The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable, expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any excess of funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

3. Funding repayable to the MOHLTC (continued)

- a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2011 Surplus	2010 Surplus
	\$	\$	\$	\$
Transfer payments to HSPs	2,042,808,997	2,042,808,997	-	-
LHIN operations	4,826,753	4,748,677	78,076	48,666
Aging at Home			-	-
ER/ALC	100,000	96,714	3,286	-
ED/Lead	75,000	69,290	5,710	-
Critical Care	75,000	72,000	3,000	-
E-Health	632,000	356,450	275,550	177,553
Aboriginal Planning	20,000	-	20,000	-
French Language Services	170,116	51,665	118,451	100,000
Aboriginal Health Transition Funding Carryover	47,202	9,980	37,222	-
Resident's First			-	(900)
	2,048,755,069	2,048,213,773	541,295	325,319

- b) The amount due to the MOHLTC at March 31 is made up as follows:

	2011 \$	2010 \$
Due to MOHLTC, beginning of year	354,269	28,950
Recovery by MOHLTC during the year	(354,269)	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	541,295	325,319
Due to MOHLTC, end of year	541,295	354,269

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2011 \$	2010 \$
Balance, beginning of year	369,310	380,725
Capital contributions received during the year	112,939	249,478
Amortization for the year	(166,962)	(260,893)
Balance, end of year	315,287	369,310

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due to 2016 are as follows:

	\$
2012	238,373
2013	236,537
2014	232,949
2015	228,331
2016	133,193
	<u>1,069,383</u>

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs based on the current accountability agreements are as follows:

	\$
2012	2,008,452,427
2013	<u>2,008,379,827</u>

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

	2011	2010
	Net book value	Net book value
	\$	\$
Cost	Accumulated amortization	
\$	\$	
Office furniture and fixtures	452,180	370,494
Computer equipment	258,765	190,628
Web development	36,100	36,100
Leasehold improvements	668,028	502,564
	<u>1,415,073</u>	<u>1,099,786</u>
		81,686
		68,137
		-
		165,464
		<u>222,968</u>
		<u>369,310</u>

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2009. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of \$2,042,808,997 is made up of the following:

	\$
Initial HSP funding budget	1,947,201,383
Adjustment due to announcements made during the year	<u>95,607,614</u>
Total HSP funding budget	<u>2,042,808,997</u>

8. Budget figures (continued)

The total revised operating budget of \$5,784,730 is made up of the following:

	\$
Initial budget as represented on the statement of financial activities	4,772,730
Additional funding received during the year for:	
ER/ALC	100,000
ED/Lead	75,000
Critical Care	75,000
E-Health	632,000
Aboriginal Planning	20,000
French Language Services	110,000
Total budget	5,784,730

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of \$2,042,808,997 (2010 - \$1,923,766,995) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2011 as follows:

	2011	2010
	\$	\$
Health Infrastructure Renewal Fund	3,271,065	
Operation of hospitals	1,206,183,380	1,124,792,403
Grants to compensate for municipal taxation		
- public hospitals	286,275	294,975
Long term care homes	387,840,154	368,756,047
Community care access centres	217,505,556	208,746,653
Community support services	29,881,514	28,341,071
Assisted living services in supportive housing	13,675,055	13,024,039
Community health centres	19,816,160	20,015,681
Community mental health addictions program	54,169,878	52,902,577
Specialty psychiatric hospitals	108,726,800	105,624,200
Acquired brain injury	1,428,560	1,245,349
Grants to compensate for municipal taxation		
- psychiatric hospitals	24,600	24,000
	2,042,808,997	1,923,766,995

10a. ED Lead

The LHIN received funding of 75,000 (2010 - \$75,000) related to the ED Lead project. ED Lead expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Consulting services	69,290	63,866
Salaries and benefits	-	-
Other	-	11,134
	69,290	75,000

b) ER/ALC

The LHIN received funding of \$100,000 (2010 - \$100,000) related to the ER/ALC project. ER/ALC expenses incurred during the year consist of \$ 96,714 (2010 - \$91,983) of salaries & benefits and \$nil (2010 - \$8,017) of other expenses.

c) Aboriginal Planning

The LHIN received funding of \$20,000 (2010 - \$20,000) related to the Aboriginal Planning project. Aboriginal Planning project expenses incurred during the year consist of \$ nil (2010 - \$ nil) of consulting fees and \$ nil (2010 - \$20,000) of other expenses.

d) E-Health

The LHIN received funding of \$632,000 (2010 - \$1,885,000) related to the E-Health project. E-Health project expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Consulting services	19,301	1,192,071
Salaries and benefits	308,718	261,421
Meetings		65,673
Supplies and other	28,431	188,282
	356,450	1,707,447

e) Critical Care

The LHIN received funding of \$75,000 (2010 - \$nil) related to the Critical Care project. Critical Care project expenses incurred during the year consist of \$72,000 (2010 - \$nil).

f) French Language Services

The LHIN received funding of \$170,116 (2010 - \$113,584) related to the French Language project. French Language project expenses incurred during the year consist of \$51,665 of salaries and benefits (2010 - \$13,584).

g) Aboriginal Health Transition Funding

The LHIN received funding of \$47,202 (2010 - \$3,798) related to the Aboriginal Health Transition Funding project. Aboriginal Health Transition Funding project expenses incurred during the year consist of \$9,980 of meeting expenses (2010 - \$3,798).

h) Self Management

The LHIN received funding of \$nil (2010 - \$35,000) related to the Self Management project. Self Management project expenses incurred during the year consist of \$nil (2010 - \$35,000).

i) Diabetes

The LHIN received funding of \$nil (2010 - \$20,000) related to the Diabetes project. Diabetes project expenses incurred during the year consist of \$nil (2010 - \$20,000).

11. General and administrative expenses

The Statement of financial activities presents the expenses by function; the following classifies these same expenses by object:

	2011	2010
	\$	\$
Salaries and benefits	3,328,839	3,212,777
Occupancy	382,055	212,745
Amortization	166,962	260,893
Shared services	409,495	378,919
Community engagement	73,075	153,588
Consulting services	71,891	113,457
Supplies	106,584	118,424
Board member expenses	120,625	107,901
Mail, courier and telecommunications	1,670	3,154
Other	87,481	103,121
	4,748,677	4,664,979

Included in general and administrative expenses are board per diems and expenses as follows:

	2011 Budget	2011	2010
	\$	\$	\$
Board chair per diem expense	50,000	41,300	50,750
Other board members per diem expense	100,000	58,947	50,279
CRA accrual historical expense		(12,729)	(30,463)
Governance costs and travel	70,000	33,106	37,335
Total expenses	220,000	120,625	107,901

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 28 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was \$ 258,290 (2010 - \$251,562) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation of the plan was completed for the plan as of December 31, 2010. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative Figures

Certain comparative figures have changed to conform to the current year presentation.

STAFF MEMBERS



Back Row

Emily Van de Klippe, Suzette Stines-Walford, Marilee Suter, Paul Barker, Elizabeth Salvaterra, James Meloche, Denys Begin, Brian Laundry, Katie Cronin-Wood, Jennifer Russell, Lisa Kitchen, Christine Laity

Middle Row

Karen O'Brien, Brittany Peterson, Eileen Longueville, Karen Landriault, Jennifer Persaud, Kirsten Schmidt-Chamberlain, Jina Mintsinikas, Charli Law, Tapas Kar, Jai Mills, Linda Henry

Front Row

Indra Narula, Amanda English, Kate Reed, Deborah Hammons, Sheila Rogoski, Jeanne Thomas, Marco Aguila, Dana Lian

Absent

Janet Boland, Ritva Gallant, Jenny Greensmith, Carolyn Kanhai, Marlene Ross Ajay Thusoo, Viola Zhou

CONTACT INFORMATION

Telephone	905-427-5497 1-866-804-5446
Fax	905-427-9659
Address	Harwood Plaza 314 Harwood Avenue South, Suite 204A Ajax, ON L1S 2J1
Email	centralcast@lhins.on.ca
Website	www.centralcastlhins.on.ca

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Local Health Integration
Network